Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Insurance Enrollment and Change Form (FORM -1)

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
— —		/ /	/

Name - Last | First | MI

Address ☐ This is a new address | City | State | Zip Code

Date Entered Service	Bargaining Unit/Union Name	HR/CMS or UMASS Employee ID #:	Home Phone	Work Phone
/ /			( )	( )

02 ☐ **LIFE, HEALTH AND LTD COVERAGE** — **Effective Date: / 01 /**

New Enrollment ☐ Change ☐

☐ **Basic Life Only**
☐ **Long Term Disability (LTD)**
☐ **Basic Life and Health** (Select one of the Health Plans below)

Annual Salary: $ _____

Salary Effective Date: _____ /_____ /_____

Cancel Coverage
☐ Long Term Disability (LTD)
☐ Health Insurance
☐ Optional Life Insurance

Health Plan

☐ Fallon Direct
☐ Fallon Select
☐ Harvard Pilgrim Independence
☐ Health New England
☐ Navigator by Tufts Health Plan
☐ NHP Care – Neighborhood Health Plan (HMO app required)
☐ UniCare/Community Choice
☐ UniCare/PLUS
☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No

☐ Individual
☐ Family

Optional Life **Please Check One:**

☐ **Automatic Increase**
Indicate Multiple Factor (1-8): _____
Multiple Factor 2-8 times is allowed only with Automatic increase. Changing from Non Automatic to Automatic requires a medical form.

☐ **Non Automatic Increase**
Amount $: _____
No more than $1000 less than annual salary rounded down to the nearest $ 1,000

☐ **Automatic Increase – Family Status Change**
Indicate Multiple Factor (1 – 4)_____

☐ **Non Automatic Increase – Family Status Change**
Amount $: _____
No more than $1000 less than annual salary rounded down to the nearest $1,000

Marriage, divorce, birth/adoption, death of spouse. Must provide proof of family status change within 31 days of the event.

Please Check One:

☐ **Smoker**
☐ **Non-Smoker**
Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates

03 ☐ **Name Change** | Previous Name | New Name

LEAVE OF ABSENCE

FOR GIC USE ONLY: **Effective Date: / 01 /**

Leave Pay Status: ☐ Part ☐ Full

04 ☐ **Leave Is:** ☐ With Pay ☐ Without Pay

Leave Type (You MUST Check one of the following):

___ Educational	*___ Maternity	___ Military Caregiver (26 weeks)	___ FMLA (12 weeks)	___ Personal Reason
*___ Personal Illness	___ Sabbatical	___ FMLA Military Exigency (12 weeks)	___ Family (for dep < age 3)	___ Other
*___ Industrial accident	___ Suspension	___ Military		

* Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date / / End Date / / Last Day on Payroll / /

05 ☐ **Return to Payroll Deduction:** First Day Back on Payroll / / **FOR GIC USE ONLY:** **Effective Date: / 01 /**

INSURED CHANGES

06 ☐ **Retirement** Date Retired / / ☐ ORP (Higher Ed Only) Fund Name:

07 ☐ **Transfer to another Agency** Name of Agency Transferred to Effective Date / /

08 ☐ **Transfer from another Agency** Previous Agency Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason _____ Termination Date _____ /_____ /_____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

SIGNATURE REQUIRED

Long Term Disability Insurance (LTD)
I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD Insurance until I have provided satisfactory medical evidence of insurability.

Optional Life Insurance
I understand that by not applying to be insured for Optional Life Insurance when first eligible, I may not apply for or increase my Optional Life Insurance until I have provided satisfactory medical evidence of insurability or I have a qualified family status change.

Deduction Authorization
I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

At Retirement
I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.

Termination
I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members • If you are enrolling in an HMO that requires a separate application, be sure to file an application with the Plan.

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision

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ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR **RETIREES:** RETURN COMPLETED FORM TO THE GIC